

Module Six

Competency 6

Interdisciplinary/Collaborative Practice

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Competency 6

Interdisciplinary/Collaborative Practice (Teamwork)

Objectives:

1. Understand the importance of collaboration (teamwork) in the provision of quality end-of-life care
2. Understand necessary steps to interdisciplinary collaborative practice
3. Realize the importance of Interdisciplinary Rounds and the impact on patient, family and staff.
4. Be knowledgeable of different styles of leadership and effects on team function
5. Identify different power sources in the team

Definitions

Team A team is a small number of people with complementary skills who are committed to a common purpose, set of performance goals, and an approach for which they hold themselves mutually accountable.

Myths

1. If we work together we will eventually become an effective team
2. There are no leaders on teams, everyone is equal
3. Everyone is accountable for everything on teams
4. Teams take a long time to get up and running
5. All decisions must be made by consensus
6. Conflict must be worked out for a team to be productive
7. On the best of teams everyone likes everyone else
8. The most important work of the team takes place at its meetings
9. Confrontation means conflict

Patient and family needs, along with available resources is what dictates the composition of the interdisciplinary team that provides palliative care. The common denominator is the nurse and physician on the team. All disciplines on the palliative care team uses his/her own tools, abilities, knowledge and skills to improve the quality of care for patients and families and their expertise in respective areas should be valued and respected. Teams provide opportunities to individuals to solve problems that they may not be able to solve on their own. The team members of a palliative professional interdisciplinary team may include; physician, nurse, social worker, chaplain or counselors, health care aids, pharmacists, speech, physical and occupational therapists and trained volunteers (some literature does not recognize the volunteer as part of the interdisciplinary team, however, the volunteer is recognized as part of the team for this

exam). Also it is an important role responsibility for the nurse to initiate referrals to the appropriate team members and to take a lead role at interdisciplinary rounds (for instance initiating a family conference meeting). Interdisciplinary teams are common in both hospital and community settings. They meet on regular basis to discuss patient and family's care and develop individualized care plans focusing on each patient's well being, need for pain management and symptom control. Interdisciplinary palliative care teams are able to coordinate individual patient's transition from one setting to another with as little disruption as possible.

The Steps to Interdisciplinary Collaborative Practice

Effective collaboration (teamwork) is a process of continuous communication, examination of and demonstration of respect for each other's work resulting in all of the team members assuming responsibility for the final outcome. Ferrell & Coyle (2001) have defined steps to interdisciplinary collaborative practice.

Step 1: Interdisciplinary Assessment begins with soliciting information about the patient/family situation, including their values, wishes and dreams that they feel is important to their quality of life. Subjective and objective data are collected from a palliative, comfort care perspective and these views become the driving force for the interdisciplinary team.

Step 2: Identifying Specific Issues/Problems/Opportunities and Etiology that is also defined from a palliative perspective and in this step the team differentiates between definitions of the problems that are expected norms for the dying process and those that are unexpected or may cause secondary suffering for the patient and/or family. For instance if a patient become incontinent because they are becoming weaker and nearing death the spouse may need additional support because this is a sign that the end is nearing. It is also important to determine the etiology or cause of the problem. Any causes that can be reversed at end of life should be explored. For instance a nursing diagnosis may be shortness of breath related to ineffective air exchange whereas a social worker's may feel the shortness of breath is due to anxiety because the patient has expressed to them that they feel they are being left alone.

Step 3: Interdisciplinary Team Care Planning is the process that occurs from the time the patient is referred through the family's bereavement period. It occurs both in formal IDT care planning meetings and between meetings as patient/family needs change and the members of the IDT team collaborate on the care. The key components in this process include; collaboration, patient/family directed goal setting and IDT planning of interventions. A comprehensive plan is developed by the team and goals are identified in three areas; (1) patient and family goals, (2) life-closure goals, and (3) clinical obligation goals. The interdisciplinary planning process involves determining which discipline is most appropriate to assist patients/families in accomplishing their goals. It is up to the patient and their family to determine how many disciplines they wish to be involved in their care. For instance some individuals believe only nurses should be involved in their

care and will refuse involvement of social work or chaplains. But this should not hinder the nurse from seeking advice and direction from the social worker or chaplain.

Step 4: Providing Interventions to Meet Patient and Family Goals. The hospice care plan involves interventions in four areas;

- a) palliative therapeutic interventions- these include pharmacologic and non-pharmacologic to best address the goals of the patient and family.
- b) education interventions – patient and family education is the cornerstone of palliative care nursing. The primary role of the palliative care team is to empower the patient and family so they can develop skills to comfortably provide care and find meaning and purpose in the experience. Education interventions may involve signs and symptoms of skin breakdown, administration and management of medications. Non- pharmacologic interventions may include therapeutic touch or breathing exercises.
- c) collaboration interventions- when planning interventions it is crucial to assure that the patient, family, IDT members, facility staff, attending and consulting physicians, therapists, are included in the plan.
- d) assessment interventions – ongoing assessment is necessary to determine if continuation of the care plan is effective or optimal.

Step 5: Evaluating Interventions and Continuation or Revision of a Care Plan. With the patient and family at the core of the team, evaluation begins with their perspective of the effectiveness of the care plan intervention. Basically do the interventions help them to reach their goals?

The purpose of the Interdisciplinary team model of care management is to build a caring community between the patient, family and palliative care team. This team approach is able to meet the physical, psychosocial, spiritual and bereavement needs of patient and families because these needs are inseparable. This approach is different than the traditional multidisciplinary approach where a member representing each discipline visits the patient and formulates goals depending on his/her own area of expertise. Patient and family's goals are not always considered in a holistic nature when this approach is applied. The interdisciplinary approach improves upon the multidisciplinary approach by:

1. involving the patient and family in the decision making process
2. determining the patient and family's values that direct care plan goals
3. allows collaboration of expertise by varied disciplines
4. identifies appropriate interventions that take into account the holistic nature of care
5. role blending of expertise among disciplines

Interdisciplinary Rounds

In several institutions interdisciplinary rounds are now replacing discharge rounds. This has caused a change in the focus in rounds, including the structure, membership and leadership. Participants of interdisciplinary rounds have noticed a

greater participation by all disciplines, achievement of patient and family outcomes, increased early recognition of patients at risk, and improved communication among members of the healthcare team. Interdisciplinary rounds are a valuable mechanism for improved patient outcomes and increased staff professionalism and especially fostering the promotion of interdisciplinary collaboration. The focus of interdisciplinary rounds is to plan and evaluate patient care by reviewing each patient's status, needs, and problems with all healthcare team members participating in the discussion. It has been shown in the literature that interdisciplinary rounds result in earlier identification of clinical issues, more timely referrals, preventive nursing interventions, and increased communication- all leading to better clinical outcomes, increased patient/family satisfaction and decreased length of stay. The key activities to be included in interdisciplinary rounds are; summarizing pertinent health data, identifying patient/family problems, defining goals, identifying interventions, discussing patient/family responses to interventions, discussion progress toward goals, revising goals and plan as necessary, generating referrals, reviewing discharge plans, and clarifying responsibilities related to implementation of the plan.

As for frequency interdisciplinary rounds can be daily to three times a week or less depending on the patient's changing needs and the length of stay. One advantageous of having all team members participate in interdisciplinary rounds addresses the need for staff to have accountability and responsibility for care coordination. Nurses are expected to present patients to the interdisciplinary team, coordinate various referrals, and identify interventions that support the comprehensive patient/family plan of care. Increasing the accountability of the nurse is consistent with professional hospice palliative care nursing standards that identify interdisciplinary collaboration as necessary for high quality patient care. Collaboration is the standard that emphasizes professional performance for nurses.

Leadership and Power

One style of leadership is not necessarily better than the other. Leadership style should be flexible as teams form and re-form around various issues/focuses. Effective leadership means knowing and respecting the skill and commitment of team members and should in accordance to the skill and commitment of these members.

Level of Leader Direction

Leader as Coach	Leader as supporter
Directs decision making but involves others and solicits input. Explains desired outcomes and prompts and cues behavior. Recognizes suggestions and follows direction	Gives decision making power to others but engages in a process of inquiry to help people analyze and think through issues Recognizes and supports decisions but helps to guide evaluation and development
Leader as Director	Leader as Delegator
Takes responsibility for all decisions and tells others what how and why to do things. Recognizes following directions	Gives responsibility in others to identify issues and implement solutions. Gives briefings and updates Recognizes acceptance of responsibility.

Sources of power and influence on teams:

1. Legitimate Power: arises from members recognizing the knowledge, skills and talents of an individual member that renders him/her crucial to the successful attainment of the team's goal(s).
2. Coercive power arises when one member is able to pressure individual team members or the team itself into granting him/her responsibility or roles which he/she may desire but would be better filled by another member based on knowledge and/or skills.
3. Rewards: power arising from the ability to distribute rewards and recognition is powerful and team members will try to gain his/her favor.
4. Expert/Network; Some team members may have achieved recognition in another area, and may be perceived by colleagues and peers as experts and/or may have network of acquaintances/peers/friends that would help the team achieve its goals.

When these sources of power are distributed amongst team members as is usually the case, struggles for team leadership often emerge which can compromise team performance and effect patient/family care. Recognition of the sources of distributed power on a team and using these sources of power effectively is often an important step in resolving destructive leadership struggles. On mature teams, leadership is a shared responsibility in order to achieve high quality patient care.

Leadership and Personal Accountability

Miller, 2001 proposes that if nurses use the accountability framework they will be able to build and promote healthy working relationships in the face of change, and will build teams that bring out the best in each discipline and enhance the working environment. The framework consists of three components: explicit use of "what" or "how" and an avoidance of "why", "when" or "who" questions: use of "I" statements and the avoidance of "we", "you", or "they" questions: and a focus on taking action. Nurses who practice personal accountability are always proactive and deeply committed to learning and change. To improve the quality of work life and promote the health and quality of care to patients and families nurses can use personal accountability strategies as listed in Table I.

Table 1.

Staff Nurse	Educators
<ul style="list-style-type: none"> - identify what you can do to make a positive difference, acknowledging that the work environment is not perfect. - Compliment yourself on the differences you made today. - Dress, behave and speak in ways that assert your professional identity - Respond to complaints from peers by asking for suggestions for improvement. - Never underestimate the power of one; use it to improve client care 	<ul style="list-style-type: none"> - Be a role model in using “I”, “what” and “how” statements with students. - “Have students reflect upon what personal accountability means in clinical situations - Use a personal accountability framework in conferences to deal with worklife issues that may impact client care - Prepare students to practice in the reality of today’s healthcare environment rather than in ideal circumstances. - Acknowledge publicly the efforts of nurses who role model personal accountability
Managers	Students
<ul style="list-style-type: none"> - Use “I”, “what”, and “how” questions to eliminate blaming, complaining and procrastination. - Praise yourself for the positive difference you made today. - Acknowledge the best practices on your unit and those responsible for them. - Highlight nursing’s clinical knowledge and competencies to other disciplines. - Use the power of one to improve the quality of work life on your unit. 	<ul style="list-style-type: none"> - Keep a journal of how the personal accountability framework is used to improve your clinical experience - Accept responsibility to be a lifelong learner. - Develop action plans to identify your learning needs and strategies to meet them - Acknowledge your invitations and accomplishments and ask for help as needed. - Never provide care to clients that is less than what you would accept for yourself.

Case Study

A 61 year old man is admitted to a community care hospital with abdominal pain, nausea and vomiting, and continuous hiccups. He lives in the rural Manitoba. His history includes a liver transplant in 1999 for cirrhosis. At the time they removed the old liver they found a malignant lesion. He was told it may have had a chance to spread to other parts of his body but they would have to wait and see. He then spent the next year recuperating from the liver transplant while fearing he had an underlying cancer diagnosis. Unfortunately into year two his fears came true. He was told by his family physician that he in fact had a diagnosis of liver cancer and that his prognosis was poor

and he only had a short time to live. A palliative care referral was initiated. The couple wished for a home death. His wife was a registered nurse.

- 1) As the palliative care nurse what role might you assume as a interdisciplinary palliative care team member?
- 2) Which interdisciplinary team members need to be part of his care planning?
- 3) What main focuses of care do you think need to be addressed?
- 4) Of the many benefits associated with Interdisciplinary rounds, the most valuable one is;
 1. Increased patient and family satisfaction with quality of care
 2. A possible reduction of length of stay
 3. The promotion of interdisciplinary collaboration
 4. An increased in likelihood of early identification of patients are risk
- 5) All of the following are key activities to be included in interdisciplinary rounds except:
 1. summarizing pertinent health data
 2. identifying interventions
 3. discussing progress towards goals
 4. educating family members in important aspects of patient care
- 6) Interdisciplinary rounds would be expected to occur most frequently on a
 1. rehabilitation unit
 2. palliative care unit
 3. medical unit

Answer:

- 1) Team Leader, case manager and provider of specialized end-of-life care
- 2) Family Physician, Attending Physician, Rural palliative care nursing coordinator, pharmacists, spiritual care, social work, nutritional services.
- 3) Pain management and symptom control, access to palliative care services in the rural area, re-admission plan, grief, loss and bereavement support, education and appropriate planning for anticipated death in the home.
- 4) 3 (it is extremely important to have all disciplines input in patient care)
- 5) 4 (family members would be educated after interdisciplinary rounds)
- 6) 2 (interdisciplinary rounds need to be more often on units that patient's condition changes rapidly)

R E F E R E N C E S

www.palliative.info Ian Anderson Learning Modules

Miller, J (2001). The question behind the question. Denver Co: Denver Press

Gillis, A. (2003). Personal Accountability. The Canadian Nurse Volume 99(10)pg34-35.

Alberta Cancer Board, (2001). Alberta Palliative Care Resource, Alberta: Author

Cancer Pain & Symptom Management Nursing Research Group (2001). Toolkit for Nursing Excellence at End of Life Transition, University of Washington.

Ferrell & Coyle (2001). Textbook of Palliative Nursing, New York: Oxford Publishing.

Kemp (1999). Terminal Illness: A Guide to Nursing Care 2nd Edition. New York: Lippincott.

Module Seven

Competency 7

Education

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Competency 7

Education

Objectives:

1. Know how to provide information to the public about end-of-life issues and the beliefs, attitudes, and practices unique to hospice palliative care.
2. Be prepared to educate health care professionals, students, volunteers about the beliefs, attitudes and practices unique to hospice palliative care.

Definition

WHO Definition of Palliative Care

Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. Palliative care:

- provides relief from pain and other distressing symptoms;
- affirms life and regards dying as a normal process;
- intends neither to hasten or postpone death;
- integrates the psychological and spiritual aspects of patient care;
- offers a support system to help patients live as actively as possible until death;
- offers a support system to help the family cope during the patients illness and in their own bereavement;
- uses a team approach to address the needs of patients and their families, including bereavement counseling, if indicated;
- will enhance quality of life, and may also positively influence the course of illness;
- is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.

WHO Definition of Palliative Care for Children

Palliative care for children represents a special, albeit closely related field to adult palliative care. WHO's definition of palliative care appropriate for children and their families is as follows; the principles apply to other pediatric chronic disorders (WHO; 1998a):

- Palliative care for children is the active total care of the child's body, mind and spirit, and also involves giving support to the family.
- It begins when illness is diagnosed, and continues regardless of whether or not a child receives treatment directed at the disease.
- Health providers must evaluate and alleviate a child's physical, psychological, and social distress.
- Effective palliative care requires a broad multidisciplinary approach that includes the family and makes use of available community resources; it can be successfully implemented even if resources are limited.
- It can be provided in tertiary care facilities, in community health centres and even in children's homes.

Myths

1. Hospitals are the best places for be when you have a life threatening-illness and are going to die.
2. Non-hospital (nursing homes, home care and hospice) care systems are required to be licensed and certified to provide end-of-life care.
3. Hospice is a specific place where old people go to die.
4. Hospice is only for people with cancer.
5. Hospice can help only when family members are available to provide care.
6. Palliative care means access to a palliative care bed

End-of-life issues and the beliefs, attitudes and practices unique to palliative care

Palliative care is a therapeutic approach that is appropriate for all nurses to practice. In palliative care nursing it is the active total care of patients whose disease is not responsive to curative treatment and focus is on control of pain, symptom management, psychological and spiritual distress. The relationship, together with the knowledge and skills of the nurse is the essence of palliative care nursing. Palliative care can be as aggressive as curative care but the focus is on comfort, dignity, quality of life closure and patient and family autonomy. By anticipating and preventing the negative effects of physical symptoms suffering can be decreased, which allows the patient and family energy to address their personal life closure goals. Enhancing quality of life is the primary goal of palliative care and the patient and family is the unit of care.

It is essential that the nurse keep the patient and family aware and educated of progression of advanced illness such as functional decline that includes:

- loss of bladder and bowel control
- changes in appetite and fluid intake
- changes in level of responsiveness
- fear- of abandonment by health care providers not focused on “doing everything” but rather “doing nothing”. If health care providers are focused on doing nothing this may result in neglect and if they are focused on doing everything this can lead to harmful treatments.

Options of care settings

Palliative Care is not defined by a distinct physical setting or transferring to a palliative care “bed”. Palliative Care is about a philosophy and/or service of care. Despite family and community support, most Canadians will need some form of care from the health care system before death. This care will likely be in the form of professional clinical services, counseling and practical assistance for both medical and non-medical needs. Care systems may be discrete organizations or loosely connected community services and institutions but at the heart of care systems are the people who determine what good care is and isn’t and arrange for its provision and monitor performance in accordance with standards. Several organizational structures provide palliative care services:

- Community-based; home care. Palliative care services are brought to the patient’s home
- Hospice – this is free standing facilities (i.e., Jocelyn House, Grace Hospice)
- In-patient palliative care unit. Units set up distinctly for palliative care patients who have hard to manage symptoms that cannot be relieved in other settings.
- Community Hospital designated palliative care areas. Some hospitals have designated specific beds on a particular area for palliative care patients.
- Personal Care Homes- some personal care homes have trained staff to provide palliative care services to residents. Personal Care homes are

considered part of the community-based options as personal care home are they resident's home.

Education and Competency

All health care providers must be competent at providing the core skills of hospice palliative care and therefore must have the attitudes and knowledge necessary to address palliative care issues, be skilled at the process of providing care related to each of these issues and change their own behavior as they manage these issues. Healthcare Educators should be able to adapt the Canadian Hospice Palliative Association Norms of Practice for patient and family care. The CHPCA Norms of Practice Model is particularly useful to guide development of educational standards for hospice palliative care experts:

- a) Nurses: CHPCA Palliative Care Nursing Standards of Practice 2002 have been developed in collaboration with the Canadian Nurses Association and nursing certification through the National Board for Certification of Hospice and Palliative Care Nurses in the U.S.
- b) Physician: Standards of Accreditation for a 1-year program of added competence in Palliative Medicine, The Royal College of Physicians and Surgeons of Canada and the College of Family Physicians of Canada, as well as initial voluntary program standards for fellowship training in palliative medicine in the U.S. supported by the American Board of Hospice and Palliative Medicine.
- c) Social Workers: Competency-based Education for Social Workers, Alexandria, VA: National Hospice and Palliative Care Organization, 2001 see http://www.nhpc.org/store/category.cfm?category_id=77
- d) Medical Schools in Canada and in the U.S. that are now required to teach end-of-life care. Residency training programs in the U.S. that are now required to teach pain management and end-of-life care e.g., family medicine, internal medicine.
- e) Continuing medical education program specializing in end-of-life care, hospice care, pain management and palliative care including; The Ian Anderson Continuing Education Program in End-of-Life care, The Pallium Project, The Education for Physician on End-of-Life Care, The End-of-Life Nursing Education Consortium Project, The End-of-Life Physician Education Resource Center.
- f) Hospice Palliative Care Organizations: proposing to develop "education" as one of their principle activities. Also the "Square of Organization" and the principles and norms of practice for organizational development and function can be used to guide the development of educational activities.

Palliative Care Web Sites

www.palliative.info

www.albertapalliative.net

www.palliative.org

www.pallium.ca

<http://www.living-lessons.org/>

<http://www.cancer.gov/cancerinfo/pdq/supportivecare>

<http://www.canadianvirtualhospice.ca/survey/home.html>

<http://www.dyingwell.org/>
<http://www.growthhouse.org/>
<http://www.hc-sc.gc.ca/english/care/palliative.html>
<http://hospice.xtn.net//hospice.htm>
<http://www.hospicenet.org/>
<http://www.medicineau.net.au/clinica/palliative/home.html>
<http://www.endoflifecare.org/>
http://www.chpca.net/canadian_directory_of_services.htm
<http://www.manitobahospice.mb.ca/>
<http://www.hospicebc.org/>
<http://www.hospice.on.ca/>
<http://www.saskpalliativecare.com/>
<http://bereavementselfhelp.victoria.bc.ca/>
http://www.carelife.com/cancer_faq/cancer_faq.html
<http://www.kitchenaid-cookforthechcure.ca/>
<http://www.voicesforhospice.org/frameset.html>
<http://www.circleofcare.com/>
<http://www.compassionatefriends.org/>
<http://www.griefowrksbc.com/>